Subject: ADJUSTED RATES OF PAY AND DIFFERENTIALS FOR CERTAIN NURSES AT THE WARREN G. MAGNUSON CLINICAL CENTER OF THE NATIONAL INSTITUTES OF HEALTH

534-1-00 PURPOSE

This Instruction provides policy and procedural guidance on administering the provisions of Public Law 99-349 pertaining to rates of pay and differentials for certain nurses at the Warren G. Magnuson Clinical Center of the National Institutes of Health (hereafter referred to as the Clinical Center).

Implementation of those provisions of P.L. 99-349, which are delineated below, is designed to make the Clinical Center more competitive by improving its ability to attract and retain well-qualified nurses and enhance the execution of clinical research projects. Implementation is also expected to reduce training, advertising, and overtime costs.

534-1-10 REFERENCES

Public Law 99-349 (law)
Title 38, United States Code, Section 4107 (law)

534-1-20 COVERAGE

The po licies stated in this Instruction concerning night differential, weekend pay, and on-call pay apply to nurses who are employed at the Clinical Center. The policy related to adjusted rates of base pay applies only to nurses at the GS-7, GS-9, GS-10, GS-11, and GS-12 salary levels employed at the Clinical Center. Nurses employed in NIH Bureaus, Institutes, and Divisions other than the Clinical Center are not covered by the provisions of this Instruction.

534-1-30 BACKGROUND

On July 2, 1986 the President signed into law H.R. 4515, the Urgent Supplemental Appropriation Act for FY 1986 (P.L. 99-349). This law contains a provision that "Funds made available for Fiscal Year 1986 and hereafter to the Warren G. Magnuson Clinical Center of the National Institutes of Health shall be available for payment of nurses at the rates of pay and with schedule options and benefits authorized for the Veterans Administration pursuant to 38 U.S.C. 4107." Within HHS, initial implementation of the flexibilities provided by the legislation will be restricted to the provisions of 38 U.S.C= 4107 concerning night differential, weekend differential, on-call pay, `and increased base pay levels.

534-1-40 POLICY

A. Nurses at the Clinical Center shall receive a night differential of 10% of basic pay for each hour of work of a whole tour of duty if at least 4 hours of the tour are between 6:00 P.M. and 6:00 A.M. If less than 4 hours of the tour of duty are between 6:00 P.M. and 6:00 A.M., the 10% differential shall be paid for each hour of service between those hours. [Reference: 38 U.S.C. 4107(e) (2)]

B. Nurses performing tours of duty, any part of which are within the period commencing at midnight Friday and. ending at midnight Saturday, shall receive additional pay for each hour of service on such tour of 25% of their hourly rate of basic pay. [Reference: 38 U.S.C. 4107 (e) (10) (a) (ii)]

C. On-call pay equal to 10% of the appropriate overtime rate shall be paid to nurses at the Clinical Center for each hour they are officially scheduled to be on-call outside of the nurse's regular hours or on an officially designated holiday. [Reference: 38 U.S.C. 4107(e) (8)]

D. Clinical Center nurses at the GS-7, 9, 10, 11 and 12 grade levels shall receive basic pay at levels comparable to those authorized pursuant to 38 U.S.C. 4107. Applicable rates of basic pay are provided in Exhibit 534-l-A. These rates will be adjusted from time to time.

534-1-50 OPERATIONAL GUIDELINES

On March 18, 1987 the Assistant Secretary for Personnel Administration approved an implementation plan under which the pay adjustment provisions of P.L. 99-349 are to be effectuated by NIH (Exhibit 534-l-B) . The Assistant Secretary for Health or his designee may approve operational guidelines that may become necessary under which the provisions of section 534-1-40 will be implemented.

534-1-60 EVALUATION AND MODIFICATION .

The effects of the implementation of this Instruction shall be evaluated annually. An evaluation report that includes information on the factors enumerated in Section VII of the implementation plan (Exhibit 534-l-B) will be submitted to the Assistant Secretary for Personnel Administration. Necessary adjustments and extension of other provisions of 38 U.S.C. 4107 to nurses at the Clinical Center may be proposed to the Assistant Secretary for Personnel Administration as the result of the evaluation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Warren G, Magnuson Clinical Center - National Institutes of Health

Salary Table for Nurses .

EFFECTIVE DATE: February 14, 1988

GN GRADE	STEPS 1	2	3	4	5	6	7	8	9	10	INCREMENT
7							$26,940	$27,597	$28,254	28,911	$657
9				$30,547	$31,311	$32,075	$32,839	$33,603	$34,367	$35,131	$764
9 (Critical Care)						$32,075	$32,839	$33,603	$34,367	$35,131	$764
10	$32,336	$33,260	$34,184	$35,108	$36,032	$36,956	$37,880	$38,804	$39,728	$40,652	$924
11			$34,184	$35,108	$36,032	$36,956	$37,880	$38,804	$39,728	$40,652	$924
12	$37,646	$38,753	$39,860	$40,967	$42,074	$43,181	$44,288	$45,395	$46,502	$47,609	$1,107

Rates of pay in accordance with 38 U.S.C, 4107 and P.L. 99-349

This Schedule is applicable only to nurses assigned to the cited Clinical Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Memorandum

Date March 18, 1987

From Assistant Secretary for Personnel Administration

Subject P.L. 99-349 Implementation Plan - Phase 11

To Robert Windom
Assistant Secretary for Health

This responds to your request for approval of the implementation plan under which the provisions of P.L. 99-3A9 (relating to the adjustment of basic pay levels for certain nurses at the Warren G. Magnuson Clinical Center of the National Institutes of Health) are to be effectuated. Other aspects of implementation of the law relating to night differential, weekend differential and on-call pay were approved previously.

As the result of our technical review of the proposed plan, my staff participated in a meeting with PHS and NIH staff and requested some additional information and analysis. The implementation plan that is attached has been revised to incorporate the additional material. I am happy to approve it. The new pay rates will be effective on the pay period beginning April 12, 1987. I. share your belief that implementation will facilitate the execution of clinical research at NIH.

If questions or problems develop as implementation proceeds my staff will be available to provide all possible assistance.

Thomas S. McFee

Attachment

P.L. 99-349 Implementation Plan

PHASE 11

Special Rates of Pay for Certain Nurses at the Warren G.
Magnusom Clinical Center of the National Institutes
Of Health

Table of Contents

1

I. Introduction

The Clinical Center of the National Institutes of Health has not been able to compete successfully in the recruitment of professional nurses nor effectively retain nurses currently employed. Both problems are based primarily upon a lack of competitive salary rates. Turnover is escalating and the subsequent impact upon NIH research programs has intensified as the pay disparity between NIH and private sector hospitals continues to grow. An adequate supply of professional nurses is absolutely critical to the success of NIH clinical research programs.

On July 2, 1986, the President signed into law H.R. 4515, the Urgent Supplemental Appropriation Act for 1986 (Public Law 99-349). This law contains a provision that "Funds made available for Fiscal Year 1986 and hereafter to the Warren G. Magnuson Clinical Center of the National Institutes of Health shall be available for payment of nurses at the rates of pay and with schedule options and benefits authorized for the Veterans Administration pursuant to 38 U.S.c. 4107."

NIH proposed to implement this law In two phases. Phase I was approved and implemented effective October 26, 1986. This phase covered night differential, Saturday/Sunday differential, and on-call pay. Phase II involves the implementation of other authorities involving the adjustment of base pay rates for current nurses and the assignment of appropriate entry levels for new nurses consistent with non-Federal hospitals. These rates have been set at the minimum level considered necessary to improve the recruitment and retention of nurses at the NIH Clinical Center. In this plan, emphasis has been given to deviating only slightly from current Title 5 practices.

II. BACKGROUND

For several years the Clinical Center at NIH has been struggling to deal with an increasing shortage of professional nurses. The Clinical Center has not been able to compete successfully in recruiting nurses in the marketplace and has not been able to effectively retain those currently employed. The turnover rate for nurses is high and increasing -- approximately 25% in FY 86, up from 20% in FY 84. Currently, there are 75 nurse vacancies which equates to a vacancy rate of almost 10%. Advertising costs to recruit nurses totaled $350,000 in FY 86.

Nursing care and nursing participation in research protocols is absolutely critical to NIH and its clinical research program. At the Clinical Center, nurses participate in the research process as an integral part of the research team.

Nurses administer experimental therapy, obtain psychological ratings, and manage complex studies. They provide individual and group therapy which have been show to be vital in getting patients to participate in protocols and to support patients through demanding studies.

The lack of nurses has forced delays In the Initiation and completion of some research protocols. Currently, forty beds in the Clinical Center cannot be utilized due to a shortage of nurses. Seventeen of those beds are in the National Cancer Institute (NCI) Medicine Branch. five are in the NCI Surgery Branch, two are in the Medical Intensive Care Unit, ten are in the Neurology units, and the remaining six are throughout other institute research programs. Trying to staff operational protocols with existing staff resulted in a total overtime cost of approximately $500,000 for FY 86.

At the core of both recruitment and retention problems has been the issue of low salary levels at the Clinical Center. It has been recognized that Clinical Center salary levels are significantly lower than local competitors. In a survey of three comparable local hospitals, it was determined that the average difference in starting salary for a new graduate was approximately $5,700 less at NIH. The average difference for nurses with three years of experience was $4,200. The average difference for nurses with five years of experience was approximately $3,400. (See Attachments I through 5.) (Note: Most salary and survey data used in this plan was frozen in November 1986. Although Federal salaries increased by 3% in January 1987, according to projections by the Maryland Hospital Association, other hospital wage rates were expected to rise by similar amounts. Where 1987 salary data is used, it is specifically identified aS such.)

The relationship between nurses' pay levels and Clinical Center staffing problems has been demonstrated in two surveys at the Clinical Center that were conducted independently of each other. In the first survey, conducted by the Clinical Center Nursing Department in August 1986, 48% of the nurses cited salary as the major reason for leaving. In a second survey conducted by the Clinical Center Personnel Office and compiled in September 1986, 41% of separating nurses who participated in the survey cited salary or related reasons as their reason for leaving. Clearly, it is unlikely that there can be an improvement in the retention of nurses unless pay at the Clinical Center is more comparable with that of its competitors.

Practical results of Public Law 99-349 are an increase in base pay and differential pay for nurses. The Increase in

base pay is allowed for new hires as well as existing nurses based on the provisions of 38 U.S.C. 4107. The Phase II Implementation Plan will bring nurses' pay at the Clinical Center in line with their counterparts at competitor hospitals. The initial direct result to the Clinical Center would be a more stable workforce of nurses. Subsequent advantages include:

- Reduced cost of recruiting, orienting, and training new staff.
- Improved productivity from a high quality nursing staff in an increasingly complex and `high tech'' research setting.
- More effective implementation and completion of clinical research studies.

The development of this plan has been based upon a desire to devise an equitable system of compensation that is logical in its process, manageable in Its administration and effective in its function. At the Clinical Center there is a commitment to the role professional nurses play in clinical research, their importance, and their contribution. The Phase II Implementation Plan underscores that commitment a by providing a realistic framework for compensating nurses fairly.

This plan is designed to implement a system that will allow sufficient Improvement in the recruitment and retention of nurses at the minimum cost necessary for the continuation of the scope and quality of clinical research currently being carried out in the Clinical Center. The cost of implementing Phase II for the balance of FY 87 is estimated at $1,185,000. Given the importance NIH attaches to implementation of this legislation, funds will be reallocated within existing resources as necessary to implement these increased pay provisions.

III. PHASE II IMPLEMENTATION PLAN - P.L. 99-349

A. Title 5 Practices Remaining Unchanged

The following practices will remain unchanged; i.e., Title 5 will still be followed.

1. Position Classification of Nurses

The GS-610 nurse classification standard published by OPM will be used for certification purposes, establishment of performance standards, and other non-pay setting functions.

4

2. Appointment of Nurses/Merit Promotion/Probationary Periods

These three items are not covered by the authorities of Section 4107. As a result of the direct hire authority which the Clinical Center has had for the last several years at the GS-9 level, hiring has already been reasonably expedited. The Clinical Center expects to request additional direct hire authority. The Clinical Center will continue to use the X-118 for qualifying nurses for appointment and for merit promotions. The Clinical Center will maintain a one-year probationary period (as compared to a two-year period required by the Veterans Administration (VA)).

3. Pay-Setting Upon Promotion

Title 5 procedures and VA procedures are identical on this point of pay-setting. upon promotion to the next higher grade on individual receives either the equivalent of at least a two step increase, the minimum rate of the higher grade pay range, or the highest previous rate, whichever is greater.

4. Granting and Denying Within-Grade Increases

It is felt that the current step increase structure works well and there Is no persuasive reason to change it. The VA uses a ten step structure, although their waiting periods differ, a two year waiting period between each step. Again, the Clinical Center Is comfortable with the current Title 5 practices regarding the waiting periods for advancement to higher steps and does not see the need to change. Al SO , the WGI granting and denying process works well; therefore, no change was proposed from current Title 5 practices tying approval/denial to acceptable level of competence determinations made by supervisors.

5. Performance Appraisal

No part of Section 4107 covers performance appraisals; therefore, these procedures must be maintained in accordance with Title 5.

5

The Clinical Center currently has three positions classified above grade 12: two GS-13S (1 - Service Chief; 1 - Director, Nursing Research and Education) and one GS-15 (Associate Director for Nursing). For performance appraisal and pay purposes, these positions are in the Performance Management and Recognition System (PMRS). Consideration was given to the issue of whether these positions should be converted to the new system or retained in PMRS. The decision was made not to place the positions in the system for several reasons: (a) the pay of these nurses, while sometimes problematic In recruitment, would not be altered by conversion to the VA system; (b) the primary purpose of the legislative change did not seem directed at positions at these levels; and (c) the PMRS system of appraisal, merit increase and performance awards is working well to recognize and compensate these nurses.

6. Incentive Awards

There is no mention in Section 4107 regarding Incentive Awards. The VA does have the authority under other sections of Title 38 to grant nurses two different special recognition awards. One is for superior performance (similar to QSI) and the other In recognition of special achievement (e.g., specialty certification). It is extremely important to retain o n o ward granting mechanism for nurses in order to properly recognize high achievers and those who perform special acts of achievement. The Title 5 process and DHHS Instructions concerning the granting of Quality Step Increases o nd Cash Awards are working well in this regard and the Clinical Center will continue to grant Quality Step Increases and Cash Awards, individually or In groups in accordance with these procedures.

B. Practices Which Change as a Result of the Legislation

The following represent the changes proposed under the new legislation and the rationale for these changes:

6

1. Conversion to the VA Nurse Pay Scale (data as of 2/27/87)

Current NIH	Converted To:	VA Scale
GS-07 ($18,537-$23,883)	Associate Grade	($23,190-$25,122)
GS-09 ($22,458-$29,199)	Full Grade	($24,705-$29,199)
GS-09 (Critical Care) ($24,705-$31,446)	Full Grade	($26,203-$29,199)
GS-10 ($24,732-$32,148)	Intermediate Grade	($27,172-$33,514)
GS-11 ($27,172-$35,326)	Intermediate Grade	($28,984-$35,326)
GS-12 ($32,567-$42,341)	Senior Grade	($32,567-$42,341)

One of the most difficult issues which the Clinical Center faced was how to manage the conversion of its career ladder (which included a GS-10 level position] to the VA pay scale which does not include a level comparable to GS-10. There was a bias for retaining this position in the overall grade structure, since the GS-10 position was a significant step in the overall clinical ladder. It is felt that the best alternative is to leave the GS-10 position as it currently exists and use part of the Intermediate grade range for pay purposes. Specifically, GS-10 nurses would be paid utilizing steps 1 through 8 of the Intermediate range. This has the benefit of preserving the clinical ladder yet paying the primary nurses at a level consistent with what our competitors pay for similar duties, responsibilities, and qualifications.

2. Setting of Entry Rates

Grade	New Hire Entry Rate (VA Scale) (as of 2127/87)
GS-07	Associate, Step 7 ($23,190)
GS-09	Full , Step 4 ($24,705)
GS-09 - (Critical Care)	Full, Step 6 ($26,203)
GS-10	Intermediate, Step 1 ($27,172)
GS-11	Intermediate, Step 3 ($28,984)
GS-12	Senior, Step 1 ($32,567)

Setting new entry rates for nurses at NIH is perhaps one of the most critical pieces in the implementation of this legislation. The specific step rates were selected to be comparable with entry rates in other hospitals in this geographic location. In order to derive the information on entry rates paid for nurses at three experience levels (new graduate, mid-range nurse with approximately three year's o xperience, and a senior nurse with five or more years of experience), a pay survey was conducted by the Clinical Center nurse recruitment office in 1986. Three

7

hospitals were chosen for an indepth survey. The first two, Georgetown Hospital and George Washington University Hospital, were chosen as major teaching hospitals with significant research programs. These two hospitals also have significant ties with the Clinical Center, in some cases having nurses working on-site at the Clinical Center under contract. The third hospital, Holy Cross Hospital, was chosen as a major suburban hospital located near NIH.

The salary information from these hospitals was obtained with a high degree of reliability in method and source. The attached graphs [Attachment 2-5) show the average compensation at these hospitals and difference from NIH. A discussion about the use of differentials that were Incorporated into the various salary rate comparisons that this plan is based on is provided as Attachment 6.

Because of the 3% Federal pay comparability increase, an expanded total compensation analysis was performed in February 1987. In addition to the three hospitals previously studied, current pay data was collected from eight additional Institutions: Fairfax, National Rehabilitation, Washington Hospital Center, Prince Georges, Greater Southeast, Children's, Suburban, and Arlington hospitals.

The additional hospitals were selected as major institutions in the District of Columbia commuting area. The graph attached as Attachment 7 reflects the results of the new survey. The Clinical Center is slightly above the survey o verage for new graduates and slightly below the average for the mid and senior levels.

For those hospitals reporting (based on the Washington Metropolitan Nurse Recruiters Association Survey), the average nurse increase during the period March-November 1986 was 7.2%. This period is generally considered the period when most hospitals grant across-the-board increases. The range of increases reported was 3% - 13%. NIH nurses received no increases during this period although a 3% increase was granted in January 1987.

Several forecasting groups were consulted to determine likely salary increases during the next year:

Data Resources, Inc. (DRI) publishes a quarterly newsletter Health Care Costs. Their most recent newsletter (Fourth Quarter, 1986) forecasts a 4% increase In labor costs during 1987. This figure Is the same for both our region and the nation.

> The Maryland Hospital Association (MHA) was consulted. They receive their forecast Information from the Maryland Health Services Cost Review Commission (HSCRC) who base their

8

figures on Bureau of Labor Statistics information. They forecast a 2.8% increase during the next year. The MHA staff Indicated, however, that nurses are expected to receive greater increases than 2.8% and the funds for that increase will be offset from other occupational groups or through the use of other revenue sources (e.g., dipping Into a fund for capital improvements).

Since the majority of new hires at the Clinical Center have been and are expected to be at the GS-09 level, this rate was most closely matched with the local hospital average. According to the survey data and the scale for the VA Full Grade, a virtual identical match was found at Step 4. To set the entry rates for new graduates (GS-07/Associate) and senior staff nurses (GS-10/Intermediate) consideration was given not only to the levels paid by the other hospitals but also to internal consistency when individuals are hired at a lower rate and promoted from within, it is important that a nurse promoted from within be compensated the same as a nurse newly hired Into the system with the same background and experience. Accordingly, entry level for the GS-07/ Associate level was set o t Step 7 o nd entry level at the GS-10/Intermediate level was left at Step 1. When the differentials are added, these rates also place the Clinical Center on a competitive par with the survey hospital o verage (slightly below the average for the new graduate and mid-level nurse and slightly above the average for the senior staff nurse as reflected on Attachment 7.)

The Clinical Center currently has a special pay rate for critical care nurses. This special rate has been helpful in attracting critical care nurses and has been consistent with the higher level rates paid to these specialty nurses In most other hospitals. The Clinical Center has determined that a two step increase is appropriate to recognize work in this specialty area. The Clinical Center will set the entry level for critical care nurses at Full/Step 6, and upon conversion to this new system, will no longer utilize the special pay rate currently approved by OPM.

The Washington VA Medical Center also has set entry rates above Step 1 at the Associate level (Increased to Step 3). While our entry rate is somewhat above the VA's, the Clinical Center use of the X-118 for GS-7 contrasts with the VA qualifications at the Associate level in this way: VA requires a BSN only while the Clinical Center (X-118) requires a BSN plus superior academic achievement. The Washington VA must maintain consistency with other VA hospitals in its national network and there are other factors which differentiate VA o nd Clinical Center employment: e.g., leave, type and complexity of work, etc. To date, the VA has not been a major competitor of the Clinical Center; i.e., we neither gain many nurses from nor lose nurses to the VA. While the VA has identified recruitment and retention problems, in meetings with the Clinical Center nursing staff they have related their

problems more to the working environment and patient mix rather than salary. The VA has been fully informed regarding our plans for Title 38 Implementation and has expressed no reservation. Attachment 8 summarizes the current and proposed entry rates.

3. Exceptions to Pay Setting Practices

Exceptions to the normal entry rate may be granted with the approval of a Nursing Pay Board. The Board will consist of three core members: The Associate Director for Nursing (or designee), the Personnel Officer, Clinical Center (or designee), and the Chief, Compensation and Classification Branch, DPM. Other members will be appointed by the Director, Clinical Center on an ad hoc basis as needed for review. The reason for the exception must be documented in writing by the Board and must be based on the criteria shown in Attachment 9. Exceptional pay increases may be granted to current staff based on the same criteria.

The Clinical Center considers It extremely important to preserve flexibility in the pay-setting system to compensate nurses whose background or experience is significantly above the standard or who have demonstrated special competencies. Conceptually, the approach will be similar to that followed for appointments above-the-minimum. Considerations for granting a special exception would include: unusually high or unique qualifications of the individual as evidenced by advanced degrees or certifications, published articles, etc.; existing pay level; and/or the special need of the Clinical Center for that individual's services. Since the basic entry rate has now been competitively set, it is not expected that there will be many exceptions granted (e.g., no more than 20 per year). Attached is a hypothetical example of a nurse whose background and special qualifications would make her/him a candidate for an exception. (See Attachment 10.)

Similarly, it is considered equally important to consider granting a special increase to a currently employed nurse who on her/his own initiative may demonstrate a special competency, publish significantly, receive professional certification, etc.

The process established and the general criteria considered are similar to common VA practices of their professional standards review boards for nursing.

4. Pay Adjustments for Current Staff

As a one-time conversion into the new system, the following pay adjustments are proposed for current staff:

GS-07 - Placement in Associate grade range and pay adjustment to Step 7

10

GS-09 - Placement In Full grade range and pay increase of three steps

GS-10 - Placement in Intermediate range in accordance with normal promotion rules (maximum Step 8)

GS-11 and GS-12 Placement in Intermediate (GS-11) or Senior (GS-12) grade range, and a pay increase of two steps

NO pay adjustment under this plan may take an Individual beyond the maximum of the pay range (or Intermediate, Step 8 for GS-1OS).

Adjustment of pay of current nurses is necessary to avoid inconsistency of pay between current staff and new staff being hired and as a morale/retention Incentive. Nurses at the GS-07, GS-09, and GS-10 levels will receive adjustments consistent with the entry rate for new nurses. Current Clinical Center GS-07 nurses are new graduates who have been in the organization less than one year. Their pay will be adjusted to the level (Step 7) at which they would have entered under the new system. The Clinical Center GS-09 nurses have been employed varying lengths of time and are at various steps within the GS-09 (Fu1l) range. Since the difference between entry in the previous system (Step 1) and the new system (Step 4) is three steps, it was considered most equitable to adjust the pay of these nurses three steps to maintain comparability with the new system. GS-10 nurses will be placed in the Intermediate scale (equivalent to two step increases]. This Increase, although not as much as the GS-09s will receive, will place the GS-1Os at the proper pay level in the Intermediate grade range consistent with their seniority and achievement.

It is considered essential for morale and consequent retention purposes that our most senior nurses also receive some immediate benefit from conversion to the new system. Host of the nurses- at this level have been employed at the Clinical Center for several years and have been promoted through the ranks. They represent those nurses in whom the Clinical Center has Invested the most and who consequently, contribute the most to patient care of the Clinical Center's most difficult patients. The amount selected for increase for this group (the GS-IIs and GS-12s) was a small amount, two steps, but was considered a highly significant element in the overall conversion scheme. This two step increase is equivalent to that which the current GS-1Os will receive and will maintain a constant pay differential between the current GS-10s and the more senior nurse group. To leave this group out altogether or only to offer them an insignificant amount would be extremely damaging to morale and negatively affect retention.

The three nurses at grade GS-13 and above are not being converted into the new pay system and will receive no increases (see previous discussion on pages 8 and 9).

11

A copy of the new pay table which reflects the salary rates for the nurses at the Clinical Center who will be affected by this plan is attached as Attachment 1l.

V. COMPARISON WITH WASHINGTON VA MEDICAL CENTER

The grade structure of the NIH Clinical Center (after conversion to the new system) and the Washington VA Medical Center is compared below (data as of September 30, 1986):

	Washington VA		NIH Clinical Center	
Junior	5	(1.5%)	0	(0.0%)
Associate	15	(4.4%)	30	(4.9%)
Full	45	(13.0%)	206	(33.4%)
Intermediate	223	(65.0%)	354	(57.4%)
Senior	52	(15.2%)	34	(3.9%)
Chief *	2	(0.6%)	2	(0.3%)
Assistant Director *	0	(0.0%)	0	(0.0%)
Director *	1	(0.3%)	1	(0.1%)
	343	(100.0%)	617	(100.0%)

Clinical Center not converting positions at this grade. Data displayed based on GS level.

As can be seen from the chart, at implementation the Clinical Center will have relatively more nurses at the lower grades, Associate and Full, and fewer nurses at the higher levels. While the Clinical Center operates somewhat differently because of its total research setting, the duties of nurses at the Clinical Center at various pay levels are considered at least comparable to those same level nurses at the VA.

V. IMPACT OF THE PLAN ON THE RECRUITMENT AND RETENTION OF NURSES

The plan presented is simple, straightforward, and addresses the two critical areas of concern--recruitment and retention. The setting of the GS-07, GS-09, and GS-10 salary to keep in line with our competition will improve our recruitment status. The particular emphasis placed on the new graduate GS-O7 Associate grade salary is to allow for more active recruitment of new graduate nurses so that they may be promoted within the system. Many studies demonstrate that it takes a long time to learn one's work (this is a specially true in a complex research environment) and productivity increases with time in the organization. Also, if we enter more nurses at lower levels in the system, through promotion we can offer them a greater retention Incentive.

Pay adjustments for current staff are a significant retention factor . As a result of the existing vacancies, current nursing

staff have had to work harder and longer hours, frequently leading to increased stress and burnout. In addition, they are called upon to orient and teach large numbers of new staff which Is an additional responsibility.

The Clinical Center estimates that a net reduction of 35 can be made in the number of vacant nurse positions over the course of a year post-implementation . This estimate is based on data obtained from exit surveys identifying the number of nurses who left the
Clinical Center citing salary as a reason and information from the nurse recruiter concerning the number of nurses who declined interviews or selection based on salary. It is anticipated that with the implementation of the new system, the turnover rate for nurses at the Clinical Center can be reduced from 25% down to the national average of 19%. The Clinical Center has built options into its FTE control system to accommodate the planned increase in nursing staff.

The effect of these additionally filled nursing positions will be felt throughout the Clinical Center, especially In support of the clinical research in cancer o nd neurology and in supportive critical care medical services. This will permit filling beds which are currently vacant because of the shortage of nurses and also enhance the overall quality of nursing care In the Clinical Center by retaining some of the most qualified nurses who would
otherwise leave because of pay. Increased retention of high quality nursing staff in an increasingly complex and highly technologically oriented research setting should lead to increased productivity and more o ffective implementation and completion of clinical research studies.

VI. COST OF IMPLEMENTATION

The annualized cost of Phase 11 implementation is estimated at $1,534,000. Combined with the cost of Phase I Implementation ($430,000), the estimated total cost of implementing this legislation Is $1,964,000.

Offsetting the implementation costs are savings, either direct or indirect, including the following:

Reduction of Overtime.....$100,000

Reduction of Advertising.....$ 50,000

Reduction in costs associated
with turnover (training,
preceptor time, productivity
loss, etc.).....$300,000

The value to the NIH of advancing clinical research opportunities by alleviating the nursing shortage cannot be assessed in terms of

a dollar savings or benefit. The significance can be seen, however, in an excerpt of a September 3, 1986 memorandum written from the Associate Director for Intramural Affairs, NIH to the Director NIH:

> The (NIH) Scientific Directors unanimously agreed today that the implementation of that provision (of the law authorizing the Clinical Center to use Title 38, Section 4107) is critical to the continuation of the scope and quality of clinical research currently being carried out in the Clinical Center. The Scientific Directors believe that without implementation of that provision, (further) curtailing of clinical research will have to occur. They also recommended that you be sdvised of their strong sentiment on this issue.

VII. EVALUATION

The Clinical Center will evaluate the effect of implementation after approximately one year. This evaluation will consider the following factors:

A. Comparison of turnover rates before and after implementation.

B. Comparison of the number and location of vacancies.

C. Assessment of actual cost reductions versus initial estimates.

D. Assessment of morale of the nursing workforce, particularly as it relates to pay.

E. Continued evaluation via exit surveys of the reasons nurses leave to determine the relevance of pay to the turnover.

F. Review of the number of unfilled beds as a result of any nursing shortage.

G. Consideration of other factors related to improved (or worsening) turnover rates.

H. Survey of local hospitals for compensation comparison.

VIII. FUTURE CHANGES

Based on the evaluation performed, some modifications to the plan or implementation of other paragraphs of Section 4107 may be indicated . Future proposals for change will be submitted for consideration by the Assistant Secretary for Personnel Administration.

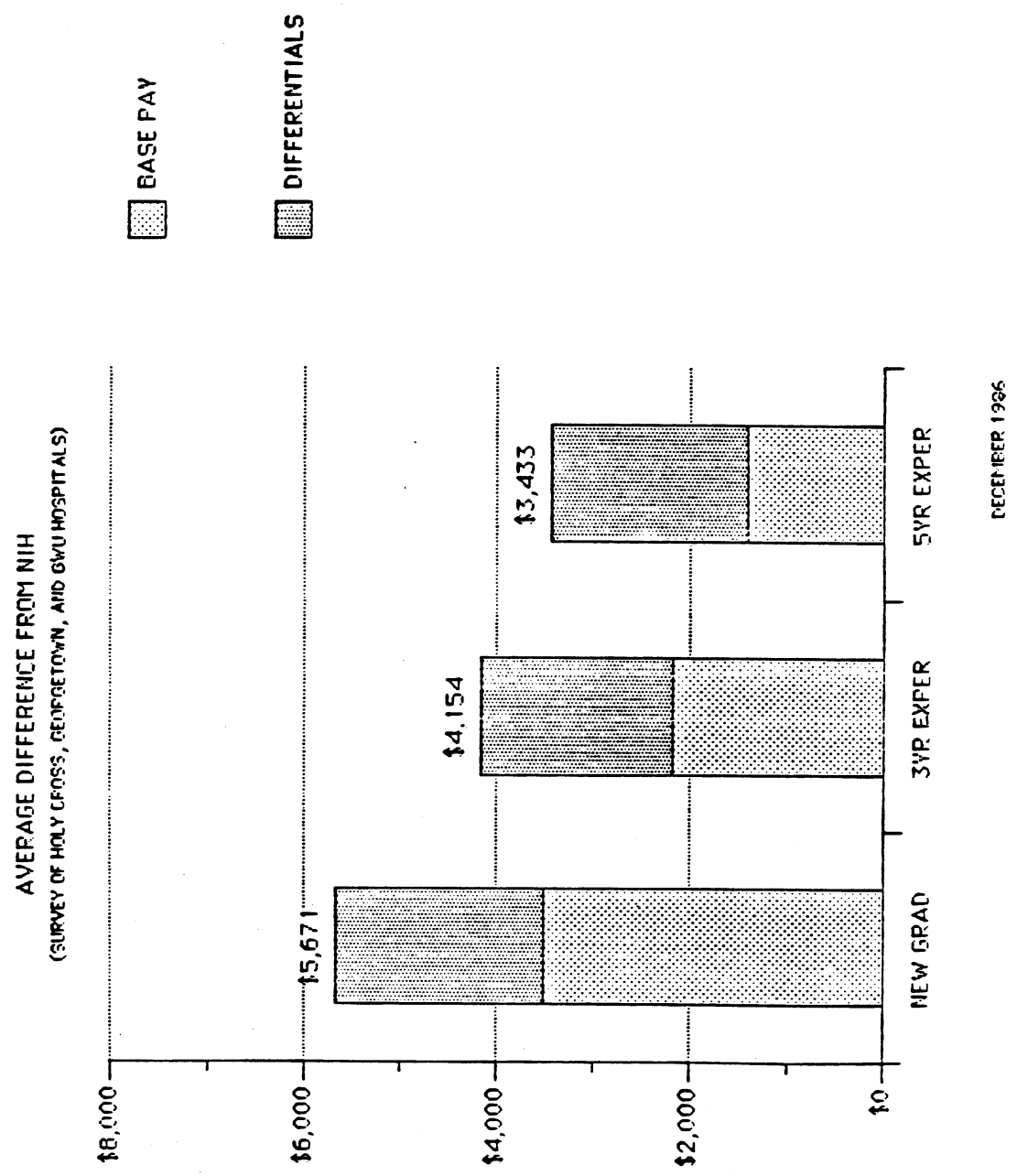
Attachment 1

NIH Clinical Center Nursing Department

Vacancies	75
Vacancy Rate	10%
Turnover Rate (FY 86)	24.6%
Total Advertising Cost (FY 86)	$350,000
Total Overtime Cost (FY 86)	$500,000

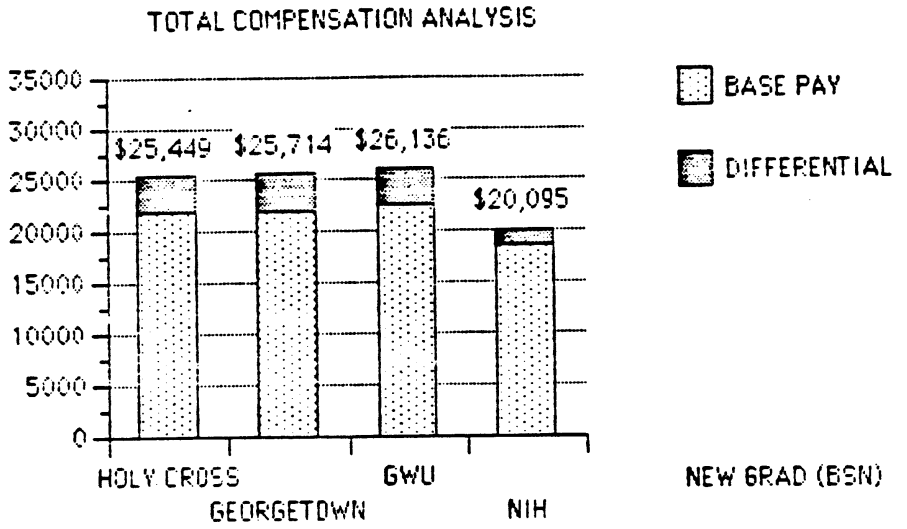
December 1986

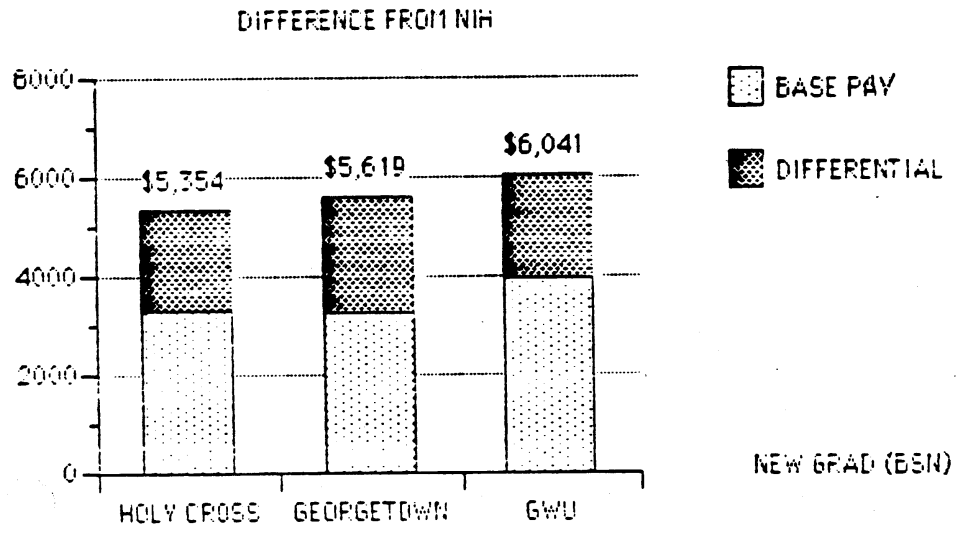
Attachment 2



Attachment 3

COMENSATION ANALYSIS FOR SELECTED HOSPITALS BASED ON THE AVERAGE HIRING RATE FOR A NEW NURSE GRADUATE (BSN)

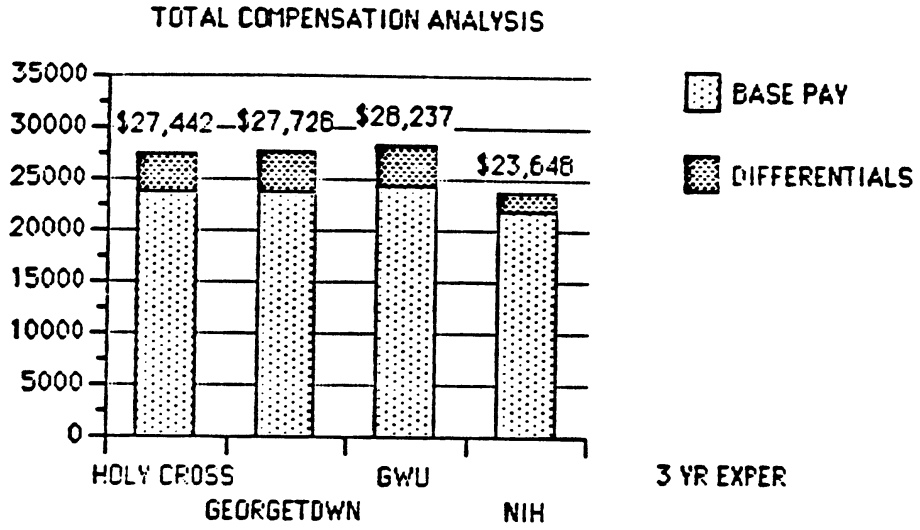


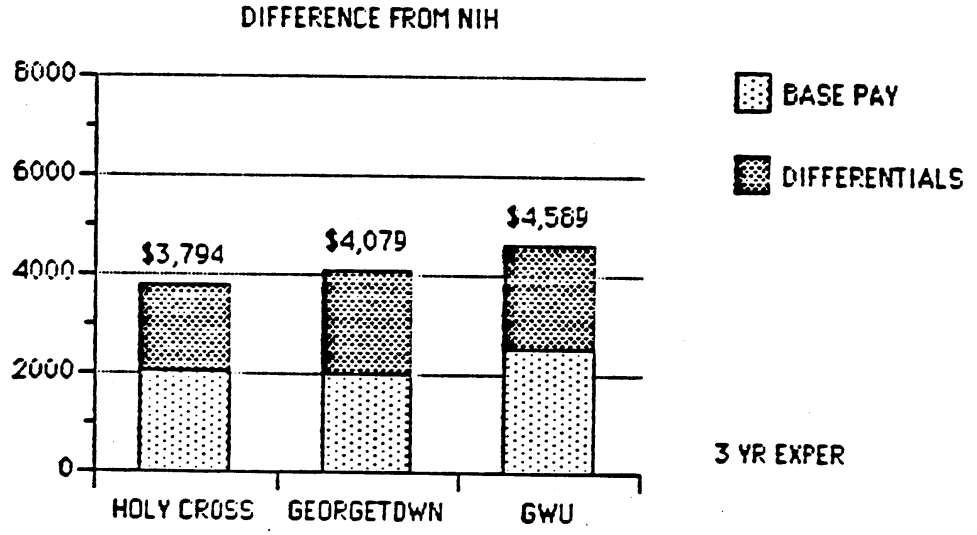


Total compensation includes both base pay and differentials

Attachment 4

COMPENSATION ANALYSIS FOR SELECTED HOSPITALS - BASED ON THE AVERAGE HIRING RATE FOR A NURSE WITH THREE YEARS EXPERIENCE

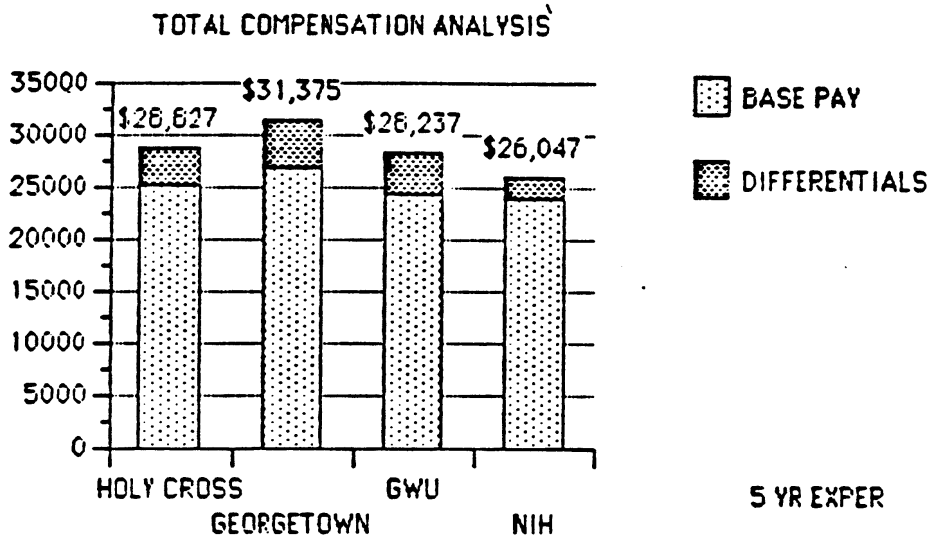


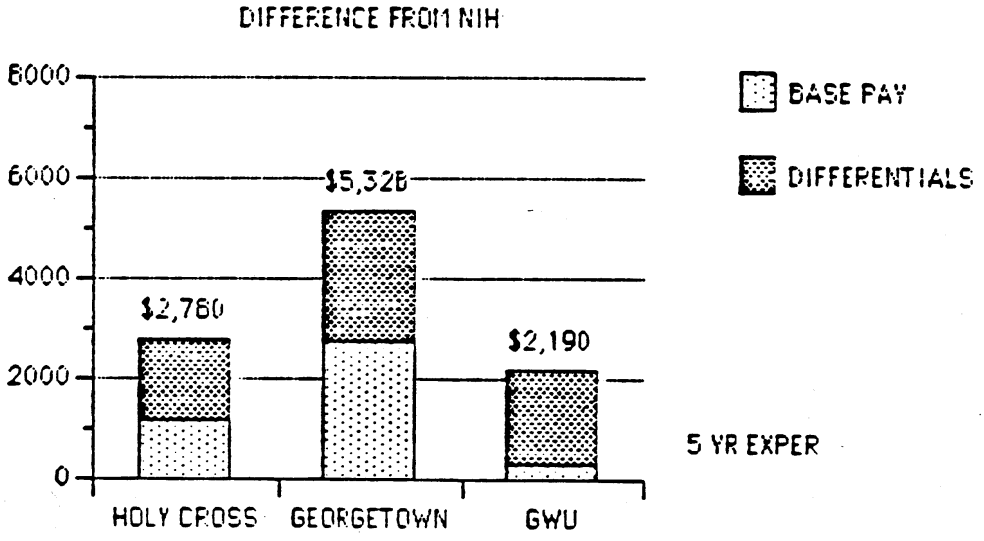


Total compensation includes both base pay and differentials.

Attachment 5

COMPENSATION ANALYSIS FOR SELECTED HOSPITALS - BASED ON THE AVERAGE HIRING RATE FOR A NURSE WITH FIVE YEARS EXPERIENCE





Attachment 6

Discussion Regarding Calculation of Differentials

In the Phase II Implementation Plan package a part of the total compensation was estimated for differtials where comparisons could be made. The method used for determining this was to assume a typical NIH nurses schedule (i.e., rotation to off-shifts and weekends) and then apply the other hospital rates to this typical schedule. Translating this to a dollar amount and then calculating Total Compensation (Base Pay plus differentials) gives a more accurate basis for comparison than base pay alone. Some hospitals choose to pay a lower base pay while increasing differentials while other hospitals adopt different compensation strategies. Hospital compensation strategies differ widely among each other due to a number of factors including union agreements, geographic location, local competitor rates for various occupations, revenues, etc.

Among the types of other benefits reported by a o ajority of other hospitals surveyed include:

Funeral Leave

100% Payment of Medical Insurance

100% Payment of Life Insurance

Tax Sheltered Annuities

Pharmacy Discounts

Cafeteria Discounts (I.e., subsidized meals)

Free Annual Physicals

Benefits reported by other hospitals (but not a majority) include:

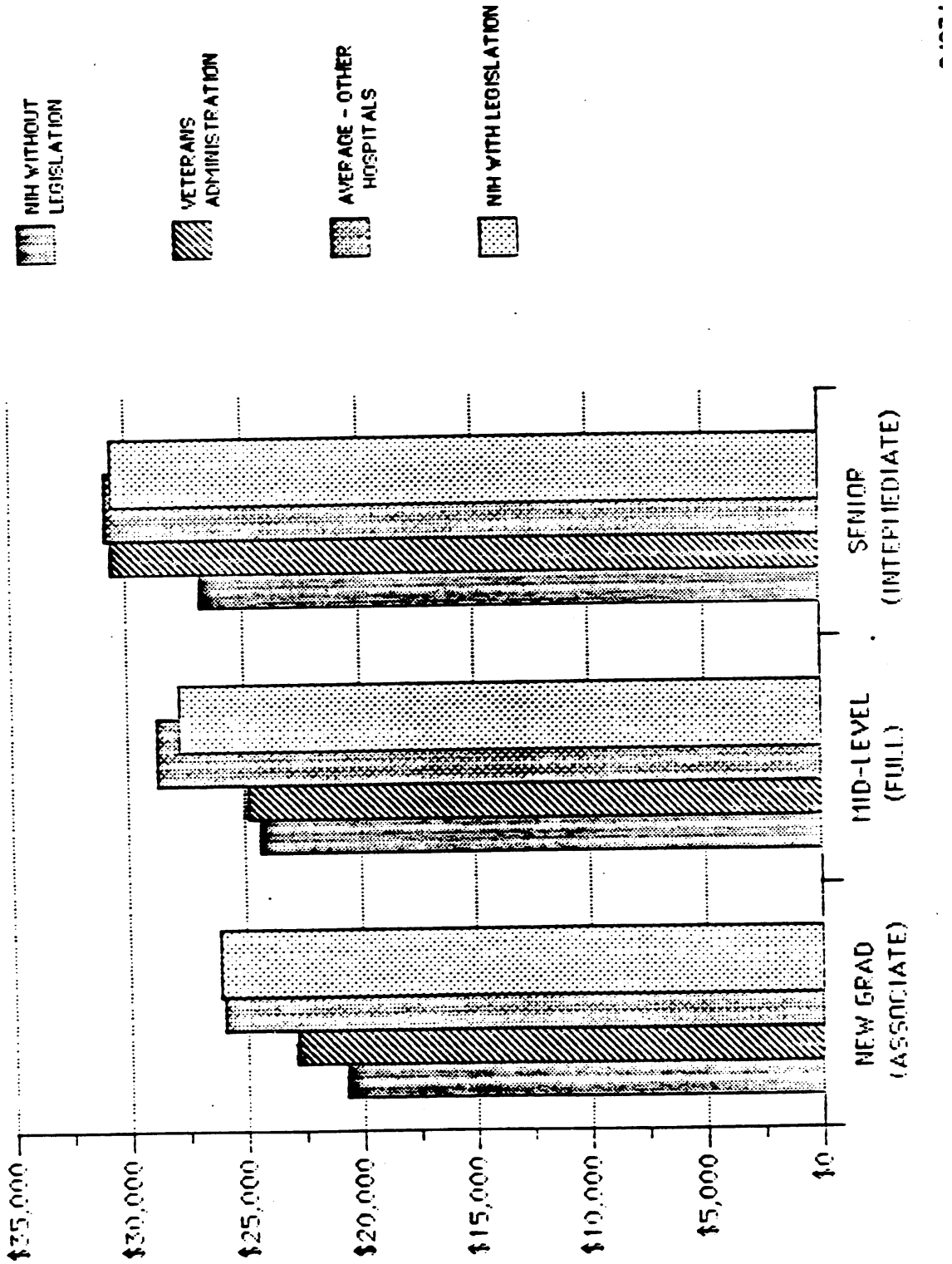
- Buy-Back of Unused Sick Leave
- Birthday Day Off
- Day Care
- Hospital Discounts
- Bonuses (usually at birthday or Christmas)
- Stock Bonus Plans

Another benefits option which is not widely used but whose use seems to be growing is the concept of flexible benefits. Under this concept, employees can trade off non-coverage of benefits for base salary increases. In most cases this is beneficial to the hospital (who will give the employee slightly less than their full cost of the benefits) and the employee who, for example, may have benefits coverage by a spouse and prefer a larger take home pay.

The following assumptions were used for calculating base pay <u>with differentials</u> throughout this plan:

- 86 evening shifts per year
- 86 night shifts per year
- 26 Saturday shifts per year
- 26 Sunday shifts per year
- balance are day shifts

Attachment 7



Attachment 8

NIH Proposed Entry Rate Comparison (Base Pay Only)
(As of 3/6/87)

	NIH Current Level	NIH Current $	NIH Proposed Level	NIH Proposed $	Survey Hospital Average
New Graduate	GS-7/1	$18,537	Assoc./7	$23,190	$22,416
Mid-Level (3 yr. exper.)	GS-9/1	$22,458	Full/4	$24,705	$25,014
Senior Level (5+ yr. exper.)	GS-10/1	$24,732	Inter./1	$27,172	$27,015

NIH Proposed Entry Rate Comparison (Base Pay and Differentials)
(As of December 1986)

	NIH Current	NIH Proposed	Survey Hospital* Average	VA
New Graduate	$20,095	$25,327	$25,767	$22,168
Mid-Level (3 yr. exper.)	$23,648	$26,995	$27,802	$24,149
Senior Level (5+ yrs. exper.)	$26,047	$29,696	$29,480	$29,719

*Georgetown, George Washington University and Holy Cross Hospitals only.

Attachment 9

Considerations for Special Pay Increases and Higher Pay on Initial Appointment

1. Experience

   - o recency of experleace
   - o years of experience
   - o in general medical/surgery
   - o in specialty
   - o with primary nursing model
   - o with research involvement
   - o type of setting (hospital, Dr.'s office)
   - o complexity of setting (size, place)
   - o other professional work experience

2. Education

   - o recency of education (particularly continuing education)
   - o relationship to clinical work
   - o relationship to specialty (i.e., specialized critical care course, or chemotherapy certification)
   - o relationship to research

3. Professional Recogn ition and Professional Activities

   - o certification
   - o nursing honor society
   - o other professional awards
   - o professional membership and contribution to professional organization
   - o professional consultation

4. Publications/Presentations

Attachment 10

Examples of Exceptional Qualifications for
Clinical Nurse: Critical Care

I. Experience
- o More than five years.
  - o Two medical/surgery acute care.
  - o Three critical care.
- o Recency - immediate past-- 3 years critical care experience.
- o Relevancy - 900 bed university medical center with shock-trauma center and national referral base. Twelve bed medical ICU.
  - was principal investigator on research study - "Effect of Bed Elevation on Arrhythmia Frequency."

II. Education
- o BS Nursing - 1981
- o Working on MSN - medical/surgery with critical care CNS role focus. Course work so far- phys. assess.; statistics, research, health policy.
- o 30+ hours/year critical care/medical continuing education courses.
- o courses in lffe support, monitoring, crisis intervention, vasopressor drugs, etc.

III. Professional Recognition/Activities

- o CCRN 1985 - Professional certification
- o Sigma Theta Tau 1981
- o ACCN research award 1985
- o MNA nurse of the year award - exemplifies excellence in nursing practice
- o Member ANA, ACCN - active in local chapter AACN

o Piloted "nurse consultant" role between four critical care units.

o Has spoken locally at National Conference on `Critical Care patient Management Issues"

IV. Presentations/Publications

o Two publication - one of a research study

o Nine professional presentations - three at National meetings.

Attachment 11

WARREN G. MAGNUSON CLINICAL CENTER - NIH

Public Law 99-349 Nurse Salary Table Effective April 12, 1987

Grade	1	2	3	4	5	6	7	8	9	10	Amount of Step Increase
	52 Weeks in Step			104 Weeks in Step							
GS-7 (Associate)							23,190	23,834	24,478	25,122	644
GS-9 (Full)				24,705	25,454	26,203	26,952	27,701	28,450	29,199	749
GS-9 (Critical Care)						26,203	26,952	27,701	28,450	29,199	749
GS-10 (Intermediate)	27,172	28,078	28,984	29,890	30,796	31,702	32,608	33,514			906
GS-11 (Intermediate)			28,984	29,890	30,796	31,702	32,608	33,514	34,420	35,326	906
GS-12 (Senior)	32,567	33,653	34,739	35,825	36,911	37,997	39,083	40,169	41,255	42,341	1086

Subject: PAY FOR CRITICAL POSITIONS

The attached memorandum of April 8, together with its attachment, provides that up to 800 positions governmentwide can be designated, by the Office of Management and Budget in consultation with the Office of Personnel Management, for critical pay to facilitate recruitment and retention for those scientific, technical, professional, and administrative jobs that require "world class" expertise.

_____

Charles J. McCarty, III
Acting Director, Office of Human
Resource Programs

Attachment

Distribution:	MS(PERS):HRFC-001
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DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Memorandum

Date APR 8 1991

From Assistant Secretary for Personnel Administration

Subject Federal Pay Reform - Interim Delegations and Procedures

To OPDIV Heads
Regional Directors
OPDIV Directors of Personnel
Regional Personnel Officers

A number of provisions of the Federal Employees Pay Comparability Act of 1990 (FEPCA) have now been placed into effect by the Office of Personnel Management (OPM). OPM has issued interim regulations for some, while others have been made effective with the publication of final rules.

The purpose of this memorandum is to transmit delegations and instructions to permit timely implementation Of interim FEPCA provisions for employees within this Department. information contained herein will be replaced by permanent HHS delegations, instructions, or guides once OPM publishes final regulations.

Under the authority vested in me as the Assistant Secretary for Personnel Administration by memorandum from the Secretary dated January 24, 1983, I hereby delegate to the addressees, authorities as specified in the attached documents, necessary to implement interim provisions of the Federal Employees Pay Comparability Act of 1990. All new and/or modified delegations are effective as of the date of this memorandum.

Information pertaining to each covered FEPCA provision is included as a separate attachment. These attachments should be retained with related HHS Personnel Management/Administration subject matter documents until replaced by permanent issuances from this office.

Questions should be directed to Dave Selner the ASPER Federal Pay Reform Coordinator. Dave can be reached by phone at (FTS) 475-0109.

Thomas S. McFee

Attachments

OMB Bulletin 91-09 .
Pay for Critical Positions

Summary of New Authority: Up to 800 positions governmentwide can be designated, by 0MB in consultation with OPM, for critical pay (no more than 30 of these can be in the executive schedule). The purpose is to facilitate recruitment retention for those scientific, technical, professional and administrative jobs that require "world class" expertise. Once a position is approved for critical pay, the Department can set its salary anywhere up to Executive Level II. Special authorization is needed from OMB to pay up to Executive Level 1, and anything beyond that needs to be approved by the President.

Current HHS Instruction: None

Interim Changes to HHS Instruction: N/A

Other Implementing Requirements or Information:

- All requests for critical pay authority must be prepared for the Secretary's signature, contain the information specified in OMB Bulletin 91-09, and be submitted to ASPER by the OPDIV or STAFFDIV head.

- OMB will be making its initial allocation based on requests received by April 30, 1991. To ensure consideration, urgent OPDIV/STAFFDIV needs should be received in ASPER no later than April 19.1991.

- Once a position has been designated for critical pay, an incumbent's salary (if set lower than the authorized rate) can be adjusted upward only if approved by the Secretary Requests for these adjustments must come from the OPDIV/STAFFDIV head and be submitted through ASPER

- OPDIV personnel offices will be responsible for maintaining the records required by the OMB instructions and making them available to ASPER on request.